

MEDICAID WORKS

Agreement

I, _____, want to enroll in **MEDICAID WORKS**, the
PRINT ENROLLEE NAME
work incentive plan for individuals with disabilities through the Virginia Medicaid program. I understand that this is a voluntary option and that I may leave the program at any time and return to regular Medicaid coverage if I continue to meet the eligibility requirements for another Medicaid covered group. I further understand that while enrolled in **MEDICAID WORKS**, I will have a different health benefit plan, which includes all standard Medicaid benefits plus personal assistance services, instead of the standard Medicaid benefit plan usually provided to Medicaid enrollees that does not include personal assistance services. I may choose to discontinue the **MEDICAID WORKS** benefit plan at any time and return to the standard Medicaid benefit plan.

I know that I must be employed to be enrolled in **MEDICAID WORKS** and that a monthly premium payment may be required to continue to participate in this plan. I understand that I must establish at least one Work Incentive (WIN) account (a regular checking or savings account) at a bank or other financial institution to be eligible for this work incentive plan and that I must deposit all earned income into a WIN account. Through the WIN account, I can have earnings in 2014 of up to \$47,460 and I am able to use this income as needed. If I am going to save some of my earnings, I must keep it in a WIN account, where I can save up to \$33,862 in 2014.

I agree to the above requirements for **MEDICAID WORKS** and to inform my eligibility worker about changes that may affect my coverage, including but not limited to, change of address, change in employment or loss of employment. I further agree to provide any required documentation regarding my employer, employment status, earned income and WIN account(s). If I choose to discontinue enrollment in **MEDICAID WORKS** or in the benefit plan provided in this program, I will inform my eligibility worker.

Print Full Name

Social Security Number

Signature

Date